

Benefit Summary

Medical Coverage	You Pay	
	In-Network	Out-of-Network
Medical Deductible Amount you pay each year before we begin paying for most of your covered services. Individual NHTC Plan = \$500.00 Family NHTC Plan = \$1000.00	\$2,500 \$5,000	\$5,000 \$10,000
Medical Coinsurance Percentage you pay for most covered services after you have met your deductible, until you reach your out-of-pocket maximum.	20%	40%
Medical Out-of-Pocket Maximum Maximum total amount of deductible and coinsurance you pay out of your pocket for covered services during the year. Co-pays do not apply. Individual Family	\$5,000 \$10,000	\$10,000 \$20,000
Medical Office Visit Primary Care Physician (Including limited Laboratory and X-ray - see page 2) Specialist (Including limited Laboratory and X-ray - see page 2)	\$25 Copay \$25 Copay	40% after Deductible 40% after Deductible
Preventive Care Services Well Child Office Visit Only - up to age 7 Annual Physical Exam Office Visit Only - age 7 and up Annual Well Woman Includes office visit, pap smear, hemoglobin and urinalysis Routine Immunizations Mammogram 1 baseline between age 35-39 and annual starting at age 40 Prostate Cancer Screening (PSA Test) Annual starting at age 50; age 45-49 if high-risk or history of prostate cancer Colorectal Screening Starting at age 50 - options include annual fecal occult blood and choice of double contrast barium enema and/or flexible sigmoidoscopy every 5 years or screening colonoscopy every 10 years Lipid Screening 1 every 5 years Glucose Screening 1 every 3 years Osteoporosis Testing 1 baseline starting at age 50	0% \$25 Copay \$25 Copay 0% 0% 0% 0% 0% 0% 0% 0%	100% 100% 100% 100% 100% 100% 100% 100%
Emergency Care Services (Co-pay waived if admitted)	ER Copay \$150	ER Copay \$150
Laboratory and X-ray Services	20% after Deductible	40% after Deductible
Hospital Services (Pre-certification required for Inpatient services) Inpatient Inpatient Rehabilitative Services (30-day maximum per calendar year) Outpatient	20% after Deductible 20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible 40% after Deductible
Routine Maternity Services (Deductible and coinsurance for Laboratory and X-ray) Medical Services (Prenatal and postpartum care) Hospital Services	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible
Inpatient Physician Services and Consultations	20% after Deductible	40% after Deductible
Surgical Services	20% after Deductible	40% after Deductible
Home Health Services (1 visit is a maximum of 4 hours)	20% after Deductible	40% after Deductible 60-visit limit per calendar year
Hospice Services (Combined inpatient and outpatient 185-day maximum benefit while covered under plan) Inpatient Outpatient	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible
Skilled Nursing Facility Services (Same confinement limit if readmitted with same diagnosis within 60 days)	20% after Deductible 100 days/confinement limit	40% after Deductible 60 days/confinement limit
Ambulance and Transportation Services	20% after Deductible	20% after Deductible

Benefit Summary Continued

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	In-Network	Out-of-Network
Mental Health Services (Pre-certification required for Inpatient services)		
Inpatient	20% after Deductible	40% after Deductible
Outpatient	20% after Deductible	40% after Deductible
Office Visit and Therapy Services	\$25 Copay	40% after Deductible
Alcohol and Chemical Dependency Treatment Services (Pre-certification required for Inpatient services)		
Inpatient	20% after Deductible	40% after Deductible
Partial Day Program	20% after Deductible	40% after Deductible
Outpatient	20% after Deductible	40% after Deductible
Durable Medical Equipment (\$5,000 maximum benefit per calendar year) Pre-certification required on Negative Pressure Wound Care Pump, C-PAP, BI-PAP, V-PAP and CPROM.	20% after Deductible	100%
Outpatient Rehabilitative Therapy - Physical, occupational and speech therapy (30-visit maximum for each therapy per calendar year)	20% after Deductible	40% after Deductible
Outpatient Cardiac Rehabilitation-Phase II (20-visit maximum per calendar year)	20% after Deductible	40% after Deductible
Transplant Services (Pre-certification required for all services)	20% after Deductible	100%
Chiropractic Office Visit (20 visit maximum per calendar year) (Co-pay covers chiropractic office visit and manipulation only. Coinsurance and deductible apply to all other covered services)	\$25 Copay	100%
Lifetime Maximum Maximum amount each covered member is eligible to receive under this plan for covered services in his or her lifetime.	\$5 Million	

Pharmacy Coverage	You Pay		You Pay
	In-Network		
Pharmacy Deductible	\$100 Deductible per member - Waived for Generics		
Prescription Drugs	30-Day Supply	90-Day Supply*	
Generic Drugs	\$12 Co-pay	\$36 Co-pay	100%
Brand-Name Drugs on Formulary	\$35 Co-pay	\$105 Co-pay	100%
Brand-Name Drugs not on Formulary	\$50 Co-pay or 50% of charges (Whichever is greater) Oral Contraceptives \$16/\$30 Co-pays Call Unified Life at 1-800-342-2641	\$150 Co-pay or 50% of charges (Whichever is greater)	100%

* Maintenance drugs may be dispensed in a 90-day supply through mail order or through a participating pharmacy that has agreed to dispense a 90-day supply.

Prior authorization: some prescriptions require prior authorization before they may be obtained.

Medical Office Visit Including limited Laboratory and X-ray

- Laboratory and X-rays that have the same date of service and billed by your physician will be covered under your medical office visit co-pay.
- Laboratory and X-rays not included on your physician's bill will be subject to your deductible and coinsurance, such as hospitals, different physicians, surgical centers and reference labs.
- The following list of services, even if billed by your physician, will be subject to your deductible and coinsurance, including but not limited to: PET scan, MRI, CT scan, SPECT scan, cardiovascular services, nuclear medicine services, radiation therapy, chemotherapy and blood transfusions.

In-network and out-of-network benefits accumulate separately. To find an in-network health care provider, refer to your online directory at www.AveraHealthPlans.com or call our Service Center at (605) 322-4545 or toll-free at 1 (888) 322-2115.